

Utah Department of Health, Bureau of EMS
UTAH TRAUMA SYSTEM

HOSPITAL TRAUMA TRANSFER PROTOCOL

This protocol was developed by the Protocol, Education and Prevention Sub Committee (PEP), endorsed by the Trauma System Advisory Committee and has been adopted by the Utah Department of Health, Bureau of Emergency Medical Services, Trauma System 288 North 1460 West, Salt Lake City, Utah 84114-2004. (1-800-284-1131). Local protocols that deviate from this State protocol will require approval by the Bureau of Emergency Medical Services.

PURPOSE

The majority of patients sustaining injury will be able to receive prompt and comprehensive medical care in local hospitals. However, patients with serious injury may require transport to a more definitive designated Level I or II Trauma Center.

The purpose of the Hospital Trauma Transfer Protocol is to ensure that early identification, appropriate and timely trauma patient transfers occur to the most appropriate facility with the capabilities and resources to care for the trauma patient. An appropriate facility means a designated Level I or II Trauma Center.

OBJECTIVE

The Utah Hospital Trauma Transfer Protocol is a tool to assist the physician and the hospital in the decision-making process for transfer of trauma patients to a designated Level I or II Trauma Center.

GUIDELINES

Transfer Identification: When a patient requires a level of care or additional resources that are unavailable at a hospital and transfer of that patient to a designated Level I or II Trauma Center is warranted, it is the responsibility of the transferring physician to initiate arrangements for transfer. These responsibilities include discussions with the receiving Trauma Center physician concerning pre-transfer stabilization, level of care necessary for the transfer and mode of transportation.

Patient Stabilization: The transferring physician is responsible for stabilization of the patient within the capabilities of the transferring hospital, without delaying the transfer.

Acceptance/Consent: The transfer should not occur until the receiving physician and the designated Level I or II Trauma Center have agreed to care for the patient, have received all available verbal information to best provide that care, and the patient or responsible party has consented (if possible) to the transfer.

Mode of Transportation: The mode of transportation and level of care necessary for transfer is the responsibility of the transferring physician. The transferring physician should consider medical factors that the patient may encounter during transfer. These medical factors include known medical problems, potential problems/complications, medical needs (time limited treatment, tertiary care, special therapy), available resources and other conditions such as weather, traffic and geography. The transferring physician should be confident that the mode of transportation meets or exceeds the patient's known and expected medical needs.

Documentation: The transferring facility is responsible for ensuring that all necessary documentation, diagnostic studies, workups and transfer forms arrive with the patient at the receiving designated Level I or II Trauma Center, is faxed prior to patient arrival.

ALL HOSPITALS AND TRAUMA CENTERS ARE RESPONSIBLE FOR COMPLIANCE WITH FEDERAL AND STATE REGULATIONS/LAWS AS THEY PERTAIN TO TRANSFER OF PATIENTS

PROCESS

1. **Facility Assessment:** Hospitals shall assess their own capabilities and resources with regard to acute trauma patient care and ensure early identification of the trauma patient that needs to be transferred to a more definitive Trauma Center.
2. **Patient Assessment and Stabilization:** Physicians shall identify patients with time critical injuries through examination and prepare patients for rapid transfer, if appropriate. Procedures such as, but not limited to, radiographs or lab tests may be performed prior to transfer if they impact the care that the patient receives at the transferring hospital. Such procedures should not be performed if doing the procedures will cause an unnecessary delay in the transfer.
3. **Protocol:** This protocol has been developed to identify "**Clinical Indicators**" necessitating a trauma patient transfer to the appropriate designated Level I or II Trauma Center. Physicians should initiate timely patient transfers as indicated.

On the attached flow chart, "**Clinical Indicators**" are located within the boxes on the left side of the page and are identified as the physician conducts the patient examination.

- **Level of Consciousness & Vital Signs:** Assess the patient's level of consciousness and vital signs. If any clinical indicators are identified and definitive surgical or critical care is unavailable, prepare the patient for rapid transfer to a designated Level I or II Trauma Center.

- **Anatomical Injury:** Examine the patient for anatomical injuries. If any clinical indicators are identified and definitive surgical or critical care is unavailable, prepare the patient for rapid transfer to a designated Level I or II Trauma Center.

- **High Energy Event/Risk for Severe Injury:** Consider all high-energy events and associated risks for severe injury. If a high energy event is identified or if risk for severe injury is evident, continue with your complete patient examination, appropriate serial observations and continue to follow the protocol.

INITIATE TRAUMA CARE AND STABILIZATION IF NOT ALREADY DONE

If definitive surgical or critical care is needed and unavailable, prepare the patient for rapid transfer to a designated Level I or II Trauma Center.

If there are **NO** positive "**Clinical Indicators**" identified, proceed with appropriate evaluation and care.

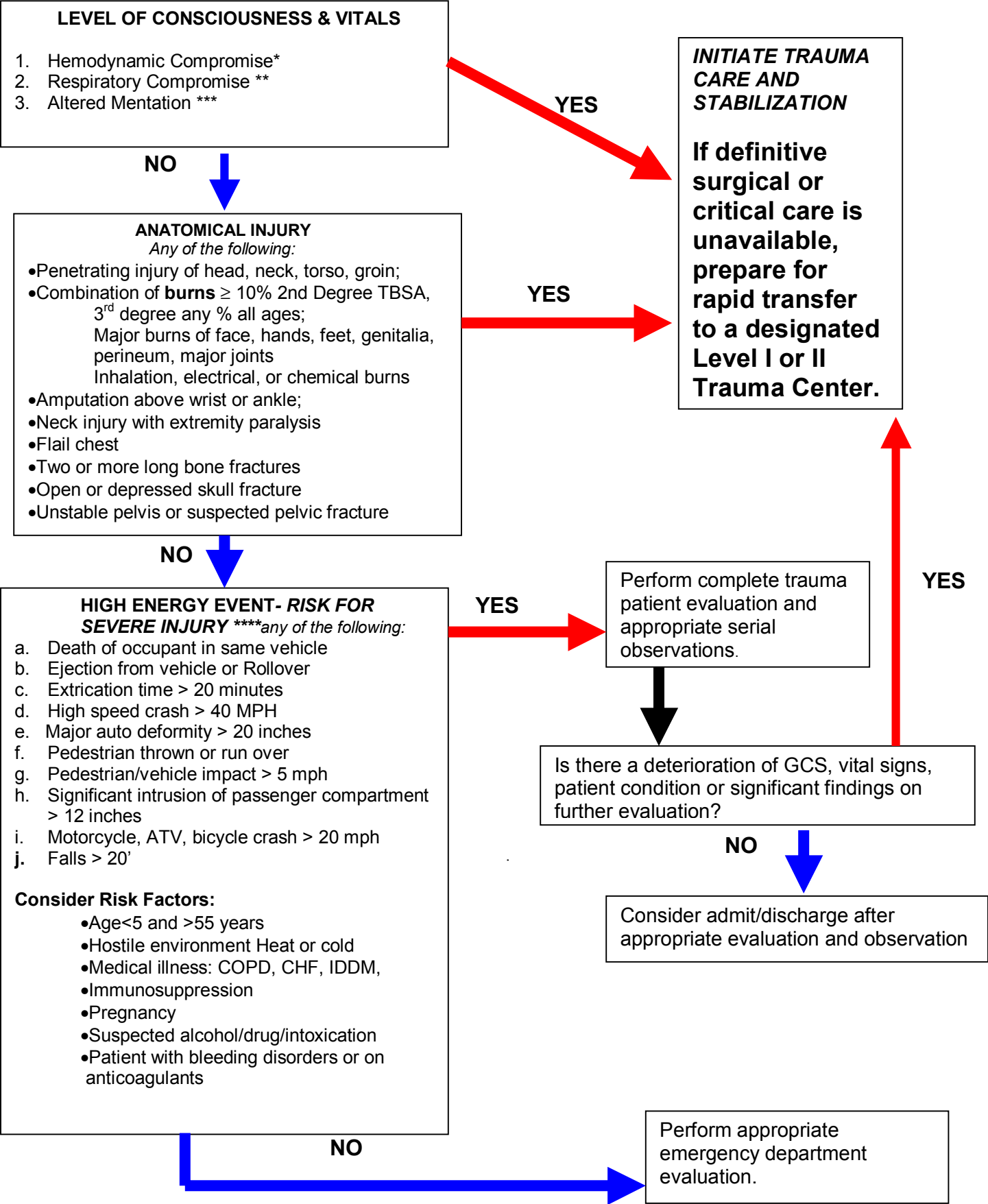
DO NOT DELAY TRANSFER FOR PROCEDURES SUCH AS RADIOGRAPHS OR LAB TESTS UNLESS THEY IMPACT THE CARE THAT THE PATIENT RECEIVES AT THE TRANSFERRING HOSPITAL.

STATE OF UTAH

HOSPITAL TRAUMA TRANSFER PROTOCOL

Effective date 7/2002

The following criteria shall be used for the identification of time critical injuries and appropriate transfer of trauma patients to an appropriate Trauma Center. This protocol was adopted by the Trauma System Advisory Committee in 2002, and derived from the American College of Surgeons (ACS) Resources for Optimal Care of the Injured Patient, 1999 and the American College of Emergency Physicians, Principles of EMS Systems, 1994.



* In addition to hypotension: pallor, tachycardia or diaphoresis may be early signs of hypovolemia.
** Tachypnea alone will not necessarily initiate this level of response.
*** Altered sensorium secondary to hypnotic-sedative will not necessarily initiate this level of response.
****High energy event signifies a large release of energy. Patient is assumed injured until proven otherwise, and multisystem injuries might exist. Determinants to be considered are direction & velocity of impact, patient kinematics, physical size and residual signature of energy release (e.g. major vehicle damage). Clinical judgement must be exercised and may upgrade to a high level of response and activation. Age and co-morbid conditions should be considered in the decision to transfer.